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17. ABSTRACT (MAX. 250 WORDS) The social and medical problem today has shifted from providing for the emergency medical needs of the indigent sick to raising the level of lower class participation in the benefits of modern medicine. Greater attention is being focused on medical deprivation suffered by large segments of the population who do not share equally in medical progress.

An analysis was made of factors affecting the seeking of medical care in a sample of 1883 adults over 21 years of age living in a certain health district of New York City to determine how differences in social organization among cultural sub-groups can lead to differing health orientations and medical behavior. Many factors were discovered which enhance the existence of medical deprivation. Cultural values were found to affect both the perception and interpretation of symptoms and the seeking of medical treatment. The social structure of urban slums makes it difficult for the low income individual to relinquish his job and responsibilities and accept the dependent role of patient. On the psychological level, medical deprivation is characterized by narrow health horizons, a low level of aspiration concerning preventive care, and a low level of expectation of avoiding disease. Financially, lower income groups are less able to afford medical care and therefore are reluctant to seek treatment.

Solving the problem of medical deprivation will involve changing values of both the lower income and public health groups. The aspirations of the medically deprived should be broadened, and medicine and public health should actively reach out and bring services to the low income population.

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MEDICAL "DEPRIVATION"*

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In keeping with the rather subtle, but extremely significant, shift in today's emphasis from the old war on indigency to the new war on poverty is a growing concern with what we will call medical "deprivation" as contrasted to medical welfare. Indigency implies an absolute need--the sick individual, usually seriously ill by the time he requires help, is almost completely lacking in the necessary resources for medical care; deprivation, on the other hand, is a relative concept--the deprived individual is not getting as much or as good medical attention, not simply care, as other individuals. The absolute need for medical care is being fairly well met under our present system--only minor socio-economic differences exist in the receipt of medical services.[1] The extensive spread of health insurance plans has, in some cases, even reversed the relationship with the lower income groups being provided with a greater amount of hospital care.[2]

Social class differentials do occur, however, in regard to the extent to which the lower socio-economic groups--and by these we mean more than a demographic income category; we imply a place and way of life, the old-fashioned slums and misery, a "culture of poverty"--share in the knowledge, values, expectations, and practices of modern medicine. It is this sharing which reflects the concept of "relative deprivation"[3]--the position one occupies

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relative to others on a scale of social advantages or privileges. From this point of view, the social and medical problem, not in all but in many areas, today has shifted from providing for or taking care of the needy, to increasing the relative share of the "disadvantaged" group. Since this is a matter of "relativity," there will always be a socially and medically deprived group since someone must be at the bottom of the heap. While the major focus of social "progress" will usually be upon raising the average level, social "reform" will usually be more concerned with the group at the bottom of the ladder; the major drive will be to secure a better deal for the "disadvantaged." It is relevant to note in this regard, however, that increasing one's share may not lead to satisfaction--it would seem that the more one gains in the way of social advantage, the more one aspires to.

Much of the problem of "better" medical care today stems from this shift in social goals from providing medical care for the indigent to increasing the privileges of the medically deprived. The "needy" have given way to the "disadvantaged." The emphasis is no longer on meeting the emergency medical needs of the indigent sick but of raising the level of participation and sharing among all members of the lower social classes in the benefits of modern medicine.

The facilities and personnel are now, for the most part, available--the problem is to secure their proper utilization. We know, for example, that early prenatal care would do much to decrease the large discrepancy in infant mortality between the upper and lower socio-economic groups, and we have built and staffed public prenatal clinics, but only a very small proportion of low income mothers take advantage of these facilities.

In summary, just as we have become concerned with the social and cultural deprivation of those who are being by-passed by the mainstream of American progress, we are increasingly aware of the medical deprivation suffered by large segments of our population who do not share equally in medical progress.[4,5,6] It is not so much that certain groups are lacking medical services, or even that the quality of such services may be correlated with ability to pay rather than medical need,[7] but that their "right" to "complete physical, mental, and social well-being and not merely the absence of disease or infirmity"--to quote the World Health Organization's definition of health embodied in its constitution--is not being fully realized. The revolution in social values which finds health and happiness being expected by the public as a basic right of the many rather than a privilege of the few has lead to increasing dissatisfaction with the current system for the organization and provision of medical care. This dissatisfaction has been buttressed by many additional factors such as the changing nature of disease from the largely preventable and curable short-term communicable diseases to the almost unpreventable and incurable long-term chronic diseases and the increasing complexity and high cost of medical care.[8]

The particular aspect of medical "deprivation" which we wish to explore in more detail concerns the relationship of the structure and values of social groups to their health orientation and medical behavior. Our basic framework is taken from a recently completed study of social patterns of medical care.[9] Based upon an analysis of factors affecting the seeking of medical care of a representative sample of 1883 adults over 21 years of age living in the Washington Heights Health District of New York City, we concluded that the

knowledge, attitudes, and responses of individuals in regard to illness and medical care functioned as significant intervening variables between their social status or group membership and their medical behavior. For example, we found that:

(1) The lower socio-economic and minority groups are significantly more socially isolated, parochial, or ethnocentric.

(2) Ethnocentrism is, in turn, highly related to lower knowledge about disease, unfavorable attitudes towards medical care, and dependency upon group support during illness.

(3) The lower socio-economic and minority groups hold these "negative" health orientations to a significantly greater degree than the upper socio-economic and majority groups with the individual's degree of ethnocentrism strengthening or weakening his conformity to the overall medical orientation of his group.

From this analysis of how differences in social organization among cultural sub-groups can lead to differing health orientations and medical behavior, we concluded that medical deprivation was basically a specific case of the more general overall social deprivation of the "culture of poverty."[10] Just as social pathology could lead to health pathology--a thesis advanced by Hanlon and Wolff--[11] social disorganization could produce medical disorganization.[12] Such factors as a low level of community organization, the absence of any recognized leadership, and inadequate channels of communication

make it difficult to build any effective medical organization or programs in the slum areas of a city. As one study of an unsuccessful attempt to secure community participation in a mass tuberculosis X-ray campaign in a low-income area in New York City concluded, "The underlying prerequisites to successful, easy community organization are the existence of organized, even if informal, communication and leadership patterns throughout the community, and sufficient social cohesion to produce identification with the community. Apparently, neither of these is present ... within a large metropolitan area .... It should be recognized also that such neighborhood organization may be contrary to trends in our society."[13]

What, then, are the major dimensions underlying social disorganization which enhance the existence of medical deprivation and how may some of these be changed? We propose the following classification of cultural, social, psychological, economic, and medical conditions--each of which reinforces the other and contributes to medical deprivation.

Cultural: The "meaning of illness" and the definition of acceptable, appropriate, and desirable medical care is largely a function of the cultural traditions and values of a group.[14] These cultural values have been found to affect both the perception and interpretation of symptoms[15] and the seeking and adjustment to medical treatment.[16] Studies of social class differences have found that the lower socio-economic groups were less likely to interpret symptoms as indicative of disease and more likely to delay seeking professional medical care.[17] Our study of the seeking of medical care found that these lower income groups, especially among the ethnic minorities, are more likely to favor a "folk" as opposed to a

"scientific" approach to medical care. For example, on a scale of popular-scientific health orientation, 57.1 percent of the lowest socio-economic group as compared to 12.0 percent of the highest, and 51.8 percent of the Puerto Ricans as compared to 15.2 percent of the white Protestants were found to hold a non-scientific or folk orientation to illness and medical care.[18] Thus, on the cultural level, medical deprivation becomes reinforced by the "culture of poverty" which places greater emphasis upon the informal social group's as opposed to the official medical care system's definition of illness and appropriate medical behavior. Much of the "disadvantaged" position of these groups can be traced to cultural values and customs which interfere with their ability to take full advantage of what medicine and public health now offer them. The strong commitment of modern medicine to an impersonal, "scientific" approach makes it difficult for the medical professional to "reach out" to these groups in their own terms. Thus, the "cultural gap" between the medical values and customs of the low-income, urban, slum dweller and those of the official medical care system contributesto the relatively deprived position of the former.

Social: Both the social structure of the urban slums with its lack of effective community organization and the social attitudes of its inhabitants are barriers to greater participation in medical programs. Slum dwellers, either through ignorance or confusion, probably a combination of both, are slow to utilize available medical facilities.[19] They are also more likely to be alienated or "anomic"--cynical, distrustful, resentful, pessimistic, and futile--toward the larger society and to reject medical care and public health services as something "they" want to give to "us." In very few instances will

the lower class groups identify with either private or official health agencies.[20] At best, motivation to utilize existing facilities will be low; at worst, it may be actually antagonistic.[21] A study by Koos of social class differences in health knowledge, attitudes, and responses to illness strongly stresses the importance of social factors in reinforcing medical deprivation.[22] It is also likely that the general feelings of the lower social classes of not having an equal share of other social and economic advantages also lead to feelings of deprivation in regard to medical care. They feel rejected and tend to reject in turn.

The social definition of the "sick role" is also likely to reflect social class differences to the medical disadvantage of the lower socio-economic groups. Social pressures will make it more difficult for the lower income individual to relinquish his responsibilities and accept the dependent status of the patient. Concern with health and illness, among this group, will be limited to a greater extent to its interference with one's job or one's normal role performance. Until an illness has progressed to the stage where the individual is forced to seek medical care, the tendency will be to deny symptoms and to delay treatment. The concept of preventive medicine in the complete absence of disabling symptoms is almost entirely foreign to the medically deprived group.

Psychological: On a psychological level, medical deprivation is characterized by narrow health horizons, a low level of aspiration concerning preventive care, and a low level of expectation of avoiding disease or living until a ripe, old age. These groups have many more salient and demanding immediate needs than the amelioration of anything but the most function-destroying illness.

Lower income groups constitute almost inpenetrable pockets of resistence to such health measures as polio immunization, venereal disease control, pre-natal care, periodic health examinations--in fact, the whole gamut of preventive medicine.[23] A study of dental care found a very low level of dentists visits for preventive treatment among the lower as compared to the upper social class groups.[24] In addition to this low level of motivation, the lower class individual is less informed about the symptoms of disease and about the available resources for meeting the occurrence of disease.[25] He is also more likely to behave emotionally than rationally in the face of disease. Kadushin has shown that lower class groups are more likely than the middle class to react violently to the threat of disease or illness.[26] These factors of alienation, ignorance, resistence, and irrationality combine to reinforce medical deprivation.

Economic: Medical care is expensive and costs are increasing daily.[27] On a purely financial basis, the lower income groups are less able to afford the high price of medical care. Add to this the loss of income due to illness and it is not difficult to understand the greater reluctance of the medically deprived to take early and full advantage of what modern medicine has to offer. While it is probably true that the indigent do receive the necessary medical care when they are ill enough and that health insurance plans have greatly lessened the economic burden of illness, it is still also probably true that the wealthy receive quicker and better medical care on the average than the poor.

Given the limited financial resources of the medically deprived, all expenditures must be on a highly competitive basis of immediate

need. It is unlikely that money could be allocated for preventive examinations, early care or rehabilitative procedures. It is also probable that saving via voluntary health insurance plans will not receive a high priority. A great deal of modern medical practice is still closely tied to ability to pay.

Medical: Finally, we must briefly note some of the factors in the organization and provision of medical care itself which reinforce social class differentials. The practice of medicine today is a highly complex, impersonal, specialized, formal, and bureaucratic venture.[28] There is very little in the atmosphere of current medical practice which would help to put the lower class patient at ease. The doctor-patient relationship is apt to be cold, business-like, and formal and to emphasize middle-class efficiency over lower-class informality.[29] The medical care is likely to involve complex tests and referrals rather than an immediate diagnosis and prescription of medicine.

In addition to the above conflict in means, there may also be differing definitions of the purpose of medical care. The doctor as a professional is interested mainly in the disease as a biological entity, while for the lower class patient the emphasis is likely to be upon its interference with his normal functioning. Finally, to the above structural conflicts must be added the possibility of prejudice and discrimination of a middle- or upper-class professional toward a lower-class worker. Evidence of such discrimination, probably largely unconscious, is provided by the many studies which show the tendency of practitioners to select and favor treatment of middle- and upper-class as opposed to lower-class patients.[30] In general, we would conclude that medical deprivation is, if anything,

reinforced rather than resisted by the formal organization of medical care today.

New Directions:

If the fields of medicine and public health are to take seriously the challenge of President Johnson's special message to Congress regarding the role of medical care in the war on poverty--"Clearly, too many Americans still are cut off by low income from adequate health services. The linkage between ill health and poverty in America is still all too plain"--then it will have to recognize that more than financial considerations are involved. The problem is with the "disadvantaged" and not the "needy." It is not so much a single battle against medical indigency as a slow, steady war against medical deprivation. In this war against deprivation, money will, of course, be necessary but it will hardly be sufficient. Building new facilities and providing more services will be of little use, unless the values and customs of the medically deprived are taken into account.

A dramatic illustration of the need for this new approach is afforded by the recent government plan to set up a job recruitment program for selective service rejects. In order to help disadvantaged young men find jobs, 234,000 rejects were offered job placement services. Only 42,000, or about 1 out of 5, responded and of these fewer than 1 out of 6 got jobs, even for a few days, slightly over 3 per cent of the total group. As interpreted in a New York Times editorial, "It is plain from these discouraging statistics that the administrators of the antipoverty program will have to devote much of their energy to combatting the sense of alienation that makes

many of those who are most disadvantaged unwilling even to avail themselves of the opportunity for help. They have become so inured to rejection tha it amounts almost to a way of life."[31] Similarly discouraging results were obtained by an experiment offering medical services to selective service rejectees with health problems.

The answer to the problem of deprivation is not an easy one. It involves changing values and behavior patterns of both the lower income and the medical and public health groups. On the one hand, the aspirations and expectations--the health horizons, if you will--of the medically deprived must be broadened. An excellent model for achieving this goal may be borrowed from the Mobilization for Youth program in New York City. Through a series of self-development projects and reinforced community organization groups, the alienation of the lower income groups must be reduced until they can come to expect, and demand, more adequate medical care. Basic to these self-help programs is the feeling that one's health does matter and that this is largely a question of personal responsibility involving greater participation in public health programs and increased utilization of available services. It is noteworthy that official public health agencies are almost completely lacking in any citizen-organized and sponsored health programs.

Changing health values must be supported by effective services. Disillusionment could be the most damaging negative side-effect of unsuccessful efforts at increasing participation. Current patterns of delivering medical and public health services are grossly inadequate. It is no longer sufficient for medicine and public health "to be available" with the necessary services; they must actively "reach out" into the community and bring these services to the lower

income population. Furthermore, they must do this in terms that are understandable and acceptable to a culture of poverty much as these may not conform to the traditional patterns of a middle-class medical and public health practice.[32]

As pointed out by Riessman in relation to mental health, a two-fold strategy is called for: "(1) modify the middle-class oriented treatment approaches (particularly in terms of the extra-scientific value dimensions) to accomodate the low-income client; and (2) educate the low-income client for the necessary aspects of treatment not suited to his expectations (e.g., low-income clients often would like a magic cure, quick pill, etc.)"[33] Unless such deliberate attempts are made to bridge the gap between the diverse expectations and styles of "scientific" versus "popular" medicine, continued divorcement of both means and ends will characterize the relationship between modern medicine and the medically deprived.

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